

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015442

FILED VS. MAY 5 1960 149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 2159 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
Length of stay in 1b 27 yrs.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5942 PARK AVE		d. STREET ADDRESS (If outside, give location) 5942 PARK AVE	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last BRIDGET KELLY			4. DATE OF DEATH Month Day Year APRIL 15, 1960		
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH JAN 30, 1869	9. AGE (last birthday) 91 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY TIPPERARY CO. IRELAND	11. BIRTHPLACE (City and state or country) USA	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME WILLIAM O'MARA	13b. MOTHER'S MAIDEN NAME ELLEN DANIELS	14. NAME OF HUSBAND OR WIFE WILLIAM KELLY
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT MARGARET VARNEL	Address 5942 PARK AVE.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Tuberculosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>massive Hemorrhage - A.S. Heart Disease</i>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 1956 to April 15, 1960 and last saw her alive on Mar 28, 1960 Death occurred at 10:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>R. R. Becker M.D.</i> (Degree or title)	22b. ADDRESS 4000 Baltimore Kansas City, Mo	22c. DATE SIGNED 4/15/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE APRIL 18, 1960	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CFM	23d. LOCATION (City, town, or county) KANSAS CITY MO.
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24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS K. M. MO.	ADDRESS	25. DATE RECD. BY LOCAL REG. 4-18-60	26. REGISTRAR'S SIGNATURE <i>Oliver Marshall</i>
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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF R. R. BECKER

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Thomas W. Harrison*

Licensed Embalmer No. 4889

P. O. Address A. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.